BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CHRISTOPHER MICHAEL REECE** **6272 Black Cinder Court** **Sparks, NV 89436** **Registered Nurse License No. 611209** RESPONDENT	Case No. 2012-381 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about December 20, 2011, Complainant Louise R. Bailey, M.Ed.,RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2012-381 against Christopher Michael Reece (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about December 26, 2002, the Board of Registered Nursing (Board) issued Registered Nurse License No. 611209 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on September 30, 2010 and has not been renewed.

3. On or about December 20, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2012-381, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record which, pursuant to Business and Professions Code section 136 and/Title 16, California Code of Regulation, section 1409.1, is required to be reported and maintained with the Board, which was and is:

6272 Black Cinder Court

Sparks, NV 89436.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about January 3, 2012, the Certified and First Class Mail documents were returned by the U.S. Postal Service with a forwarding address of 719 Trueno Ave, Camarillo, CA 93010. Respondent was re-served on January 17, 2012 to the forwarding address and on or about February 7, 2012 and February 22, 2012, the First Class and Certified mail documents were returned with another forwarding address and marked by US Postal Service, "Attempted Not Known". On February 13, 2012, respondent was re-served to 4959 Talbot Lane, Apt 17, Reno, NV 89509. On or about March 26, 2012 and March 27, 2012, both First Class and Certified mail documents were returned marked by US Postal Service "Not Deliverable as Addressed, Unable to Forward. The address on the documents was the same as the address on file with the Board. Respondent failed to maintain an updated address with the Board and the Board has made attempts to serve the Respondent at the address on file. Respondent has not made himself available for service and therefore, has not availed himself of his right to file a notice of defense and appear at hearing.

6. Business and Professions Code section 2764 states:

The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

7. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service of

the Accusation upon his, and therefore waived his right to a hearing on the merits of Accusation No. 2012-381.

9. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board after having reviewed the proof of service dated December 20, 2011, signed by Aaron Hanson, and the returned envelopes finds Respondent is in default. The Board will take action without further hearing and, based on Accusation No. 2012-381 and the documents contained in Default Decision Investigatory Evidence Packet in this matter which includes:

Exhibit 1: Pleadings offered for jurisdictional purposes; Accusation No. 2012-381, Statement to Respondent, Notice of Defense (two blank copies), Request for Discovery and Discovery Statutes (Government Code sections 11507.5, 11507.6 and 11507.7), proof of service; and if applicable, mail receipt or copy of returned mail envelopes;

Exhibit 2: License History Certification for Christopher Michael Reece, Registered Nurse License No. 611209;

Exhibit 3: Affidavit of Annette Rodriguez;

Exhibit 4: Certification of costs by Board for investigation and enforcement in Case No. 2012-381;

Exhibit 5: Declaration of costs by Office of the Attorney General for prosecution of Case No. 2012-381.

Exhibit 6: Out of State Discipline (Nevada Board of Nursing)

The Board finds that the charges and allegations in Accusation No. 2012-381 are separately and severally true and correct by clear and convincing evidence.

11. Taking official notice of Certification of Board Costs and the Declaration of Costs by the Office of the Attorney General contained in the Default Decision Investigatory Evidence

Packet, pursuant to the Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement in connection with the Accusation are $7,208.00 as of April 6, 2012.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Christopher Michael Reece has subjected his following license(s) to discipline:

   a. Registered Nurse License No. 611209

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's license(s) based upon the following violations alleged in the Accusation, which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case.

   a. Violation of Business and Professions Code section 2761(a)(1) - Unprofessional Conduct, Gross Negligence.

   b. Violation of Business and Professions Code section 2761(a)(4) - Disciplinary action by another State Board of Nursing.

   c. Violation of Business and Professions Code section 2762(a) - Obtaining or possessing controlled substances without a prescription.

   d. Violation of Business and Professions Code section 2762(e) - Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to a controlled substance.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 502272, heretofore issued to Respondent Craig Martin McKown, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on August 3, 2012.

It is so ORDERED July 5, 2012

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

default decision_LIC.rtf
DOJ Matter ID:SA2010102135

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation No. 2012-381

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CHRISTOPHER MICHAEL REECE** **6272 Black Cinder Court** **Sparks, NV 89436** **Registered Nurse License No. 611209** Respondent.	Case No. 2012-381 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about December 26, 2002, the Board issued Registered Nurse License Number 611209 to Christopher Michael Reece (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and expired on September 30, 2010, and has not been renewed.

JURISDICTION

3. This Accusation is brought before Board, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b), of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional

licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action."

8. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Code section 4060 provides:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, [or] a physician assistant pursuant to Section 3502.1."

10. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

11. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

12. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

13. Section 11173 of the Health and Safety Code states, in pertinent part:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by concealment of a material fact."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

14. Code section 4021 states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

15. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

16. Hydromorphone, also known as Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug under Code section 4022. Hydromorphone is a hydrogenated ketone of morphine and is a narcotic analgesic. Its principal therapeutic use is relief of pain. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Hydromorphone should be prescribed and administered with caution.

17. Morphine Sulfate, also known by its brand name MS Contin, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L), and a dangerous drug under Code section 4022. It is also a Schedule II controlled substance as designated by the Federal Code of Regulations, title 21, section 1308.12, subdivision

(b)(1). Morphine, which is a central nervous system depressant, is a systemic narcotic and analgesic used in the management of pain.

COST RECOVERY

18. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

19. From on or about January 2008, until on or about November 4, 2010, Respondent was employed as travel nurse for Agostini Healthcare Staffing (Agostini). From on or about April 6, 2009, until on or about May 26, 2009, Respondent was assigned to work as a registered nurse in the emergency room at El Camino Hospital (El Camino) in Mountain View, California. In or about June 2009, individuals at El Camino investigated Respondent's compliance with El Camino's policies for the administration and documentation of controlled substances. The investigation included a review of Pyxis reports and patient medical records. The Pyxis machine is a computerized management, storage, and medication dispensing machine utilized in hospital settings. The machine can only be accessed with a password or bio-identification, or both. The investigation revealed instances in which Respondent: (1) removed controlled substances from the Pyxis and failed to chart administration of the controlled substance in the patient's medical record; (2) removed controlled substances from the Pyxis in excess of the physician's order; (3) charted the administration of controlled substances in the patient's medical record prior to removing the substance from the Pyxis; and (4) failed to document the patient's site of pain, pain level, or pain scale in the patient's medical record. Respondent's conduct constituted violations of El Camino's policies for the administration and documentation of controlled substances. Below are specific examples of Respondent's violations:

PATIENT 1

a. On or about May 8, 2009, at approximately 12:51 p.m., Patient 1 had a physician's order for Hydromorphone 0.5 milligrams IV as needed for pain greater than level 1. The maximum dosage was indicated as 1 milligram, and the order specified to stop after two doses.

b. On or about May 8, 2009, at approximately 1:59 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 1. Respondent documented in Patient 1's medical record that he administered Hydromorphone 0.5 milligrams at approximately 2:00 p.m. Respondent wasted the remaining Hydromorphone 1.5 milligrams. Respondent failed to document in Patient 1's medical record the site of pain, pain level, or pain scales.

c. On or about May 8, 2009, at approximately 5:20 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 1. Respondent wasted 1.5 milligrams Hydromorphone, but failed to chart the administration of or otherwise account for the remaining 0.5 milligrams of Hydromorphone that he removed. Respondent also exceeded the physician's order for a maximum dosage of 1 milligram of Hydromorphone for Patient 1, as another nurse administered Hydromorphone 0.5 milligrams to Patient 1 at 1:15 p.m., and Respondent administered Hydromorphone 0.5 milligrams at approximately 2:00 p.m., as set forth above.

d. On or about May 8, 2009, at approximately 5:33 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 1. Respondent wasted 1.5 milligrams Hydromorphone, but failed to chart the administration of or otherwise account for the remaining 0.5 milligrams of Hydromorphone that he removed. Furthermore, Respondent exceeded the physician's order for a maximum dosage of 1 milligram of Hydromorphone for Patient 1.

PATIENT 2

e. On or about April 28, 2009, Patient 2 had a physician's order for Hydromorphone 0.5 milligrams IV as needed for pain greater than level 1. The maximum dosage was indicated as 1 milligram, and the order specified to stop after two doses.

f. On or about April 28, 2009, at 11:05 a.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 2. Respondent documented in Patient 2's medical record that he administered Hydromorphone 0.5 milligrams at 11:05 a.m., and he wasted the remaining 1.5 milligrams Hydromorphone. Respondent failed to document in Patient 2's medical record the site of pain, pain level, or pain scales.

g. On or about April 28, 2009, at 12:02 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 2. Respondent documented in Patient 2's medical record that he administered Hydromorphone 0.5 milligrams at 12:15 p.m., and he wasted the remaining 1.5 milligrams Hydromorphone. Respondent failed to document in Patient 2's medical record the site of pain, pain level, or pain scales.

h. On or about April 28, 2009, at 3:33 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 2. Respondent documented in Patient 2's medical record that he administered Hydromorphone 0.5 milligrams at 3:30 p.m., and he wasted the remaining 1.5 milligrams Hydromorphone. Respondent failed to document in Patient 2's medical record the site of pain, pain level, or pain scales. Furthermore, Respondent exceeded the physician's order for a maximum dosage of 1 milligram of Hydromorphone, and he documented administering the medication three minutes before he removed it from the Pyxis.

PATIENT 3

i. On or about May 26, 2009, at 12:27 p.m., Respondent removed from the Pyxis one Morphine 4 milligram carpuject for Patient 3. Respondent documented in Patient 3's medical record that he administered Morphine 2 milligrams at 12:30 p.m. Respondent wasted the remaining Morphine 2 milligrams. Respondent failed to document in Patient 3's medical record the site of pain, pain level, or pain scales.

j. On or about May 26, 2009, at 2:03 p.m., Respondent removed from the Pyxis one Morphine 4 milligram carpuject for Patient 3. Respondent documented in Patient 3's medical record that he administered Morphine 1 milligram to Patient 3 at 2:00 p.m. Respondent wasted the remaining Morphine 3 milligrams. Respondent failed to document in Patient 3's medical

record the site of pain, pain level, or pain scales. Respondent also documented administering the Morphine 1 milligram to Patient 3 three minutes before he removed it from the Pyxis.

PATIENT 4

k. On or about May 9, 2009, at 6:08 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 4. Respondent documented in Patient 4's medical record that he administered Hydromorphone 1 milligram at 6:05 p.m. Respondent wasted the remaining 1 milligram of Hydromorphone. Respondent failed to document in Patient 4's medical record the site of pain, pain level, or pain scales. Furthermore, Respondent documented administering the Hydromorphone to Patient 4 three minutes before her removed it from the Pyxis.

l. On or about May 9, 2009, at 8:22 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 4. Respondent documented in Patient 4's medical record that he administered Hydromorphone 1 milligram at 8:15 p.m. Respondent wasted the remaining 1 milligram of Hydromorphone. Respondent failed to document in Patient 4's medical record the site of pain, pain level, or pain scales. Furthermore, Respondent documented administering the Hydromorphone to Patient 4 seven minutes before he removed it from the Pyxis.

PATIENT 5

m. On or about April 6, 2009, at 5:25 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 5. Respondent documented in Patient 5's medical record that he administered Hydromorphone 0.5 milligrams at 5:25 p.m. Respondent wasted the remaining 1.5 milligrams of Hydromorphone. Respondent failed to document in Patient 5's medical record the site of pain, pain level, or pain scales.

n. On or about April 6, 2009, at 6:59 p.m., Respondent removed from the Pyxis one Hydromorphone 2 milligram syringe for Patient 5. Respondent documented in Patient 5's medical record that he administered Hydromorphone 0.5 milligrams at 7:05 p.m. Respondent wasted the remaining 1.5 milligrams of Hydromorphone. Respondent failed to document in Patient 5's medical record the site of pain, pain level, or pain scales.

20. From on or about June 25, 2009, to November 4, 2009, while employed as travel nurse for Agostini, Respondent was assigned to work as a registered nurse in the Intensive Care Unit (ICU) at Saint Louise Regional Hospital (SLRH) in Gilroy, California. On or about November 4, 2009, an employee at SLRH called Agostini and requested that Respondent not be returned to work due to unsatisfactory evaluations and concerns about Respondent's handling of controlled substances. An audit of Respondent's Pyxis activity while assigned to the ICU at SLRH revealed the following narcotic discrepancies:

SLRH PATIENT 3

a. On or about October 12, 2009, at 11:12 a.m., SLRH Patient 3 was admitted to the Emergency Department at SLRH. SLRH Patient 3 was discharged at 1:39 p.m. Respondent was not the primary registered nurse assigned to care for SLRH Patient 3. Patient 3 had a physician's order dated October 12, 2009, for one dose of Morphine Sulfate 8 mg. IM. This narcotic was administered by another RN on October 12, 2009, at 12:21 p.m.

b. On or about October 12, 2009, at 12:24 p.m., Respondent removed from the Pyxis one Morphine Sulfate 10 milligram/1 milliliter injectable for SLRH Patient 3. Respondent wasted Morphine Sulfate 2 milligrams, but failed to document the administration of or otherwise account for the remaining Morphine Sulfate 8 milligrams.

c. On or about October 12, 2009, at 1:53 p.m., Respondent removed from the Pyxis one Morphine Sulfate 10 milligram/1 milliliter injectable for SLRH Patient 3. Respondent wasted Morphine Sulfate 8 milligrams, but failed to document the administration of or otherwise account for the remaining Morphine Sulfate 2 milligrams. Furthermore, Respondent removed this drug from the Pyxis for SLRH Patient 3 after the patient was discharged from the hospital.

SLRH PATIENT 4

d. On or about October 31, 2009, at 8:14 a.m., Respondent removed from the Pyxis Dilaudid 1 milligram for SLRH Patient 4. Respondent wasted the Dilaudid 1 milligram at 8:40 a.m., over 25 minutes after removing it from the Pyxis.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Incompetence or Gross Negligence)
(Bus. & Prof. Code § 2761, subd. (a)(1))

21. Complainant realleges the allegations set forth in paragraphs 19 and 20 and each of their subparts above, and incorporates them as if fully set forth.

22. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a)(1), as defined by California Code of Regulations, title 16, sections 1442 and 1443, in that Respondent's conduct described in paragraphs 19 and 20 and each of their subparts above constitutes incompetence or gross negligence, or both, in carrying out usual certified or licensed nursing functions.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – False, Grossly Incorrect, or Unintelligible Entries)
(Bus. & Prof. Code §§ 2761, subd. (a), 2762, subd. (e))

23. Complainant realleges the allegations set forth in paragraphs 19 and 20 and each of their subparts above, and incorporates them as if fully set forth.

24. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a), as defined by Code section 2762, subdivision (e), in that he made false, grossly incorrect, or unintelligible entries in hospital, patient, or other records pertaining to controlled substances and/or dangerous drugs, as described in paragraphs 19 and 20 and each of their subparts, above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Unlawfully Obtain or Possess Controlled Substances)
(Bus. & Prof. Code §§ 2761, subd. (a), 2762, subd. (a), 4060)

25. Complainant realleges the allegations set forth in paragraphs 19 and 20 and each of their subparts above, and incorporates them as if fully set forth.

26. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a), as defined by Code section 2762, subdivision (a), and Code section 4060, in that he obtained controlled substances by fraud, deceit, misrepresentation, or subterfuge and/or by the concealment of a material fact in violation of Health and Safety Code

section 11173, subdivision (a). The circumstances are specifically set forth in paragraph 19, subparts (c) and (d), and paragraph 20, subparts (b) and (c).

FOURTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Out of State Discipline)
(Bus. & Prof. Code § 2761, subd. (a)(4))

27. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a)(4), in that on or about November 17, 2010, in a disciplinary action before the Nevada State Board of Nursing (Nevada Board), Case No. 0357-10C, the Nevada Board entered an Order of Voluntary Surrender of License in Lieu of Other Discipline (Voluntary Surrender Order), accepting and approving Respondent's voluntary surrender of his Nevada nursing license.

28. The Nevada Board's disciplinary action was based upon Respondent's March 10, 2010 self report to the Nevada Board that he had diverted Dilaudid from his employer for his own personal use. Furthermore, Respondent admitted that he suffered from addiction to alcohol or controlled substances, or both. Based upon these admissions, on or about May 21, 2010, the Nevada Board entered a Contract for Temporary Voluntary Surrender of License (Contract), accepting Respondent's voluntary surrender of his Nevada professional nurse license. The Contract required Respondent to discontinue the practice of nursing in any and all jurisdictions until the Nevada Board issued Respondent a conditional license and allowed him to be admitted to the Nevada Board's Alternative Program for Chemically Dependent Nurses. If Respondent successfully completed the requirements of the Contract and any subsequent Agreement for Monitoring, the Nevada Board agreed to not impose any public discipline on Respondent.

29. The Contract required Respondent to: (1) provide evidence of admission to a Nevada Board-approved chemical dependency program within 10 working days of entering into the Contract; (2) notify the Nevada Board in writing prior to any change of address; (3) be referred to the Nevada Board's Disability Advisory Committee for monitoring, evaluation, and recommendation for return to nursing practice; (4) abstain from the use of alcohol and all mood-altering drugs and controlled substances except when absolutely required for documented medical

treatment; (5) submit to urine, blood, or other tests for drugs of abuse or alcohol when requested by his counselor or a representative of the Nevada Board; (6) submit an individual aftercare plan upon discharge from the Nevada Board-approved chemical dependency treatment program; (7) participate in a Nevada Board-approved aftercare program for a minimum of 1 year; (8) submit evidence of attendance at 90 meetings of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA); (9) cause his AA or NA sponsor to submit monthly reports to the Nevada Board addressing Respondent's progress in recovery; and (10) attend weekly meetings of a Nevada Board-approved Nurse Support Group and submit monthly documentation of all meetings attended. The Contract also provided that Respondent could be evaluated and recommended by the Disability Advisory Committee for Conditional Licensure once he demonstrated and documented the following criteria: (1) compliance with the stipulations of the Contract; (2) acceptance of responsibility for his disease and recovery; (3) a stable environment and positive support system; (4) identification of the risk factors related to his return to work in nursing and his plan for minimizing the possibility of a relapse; and (5) presentation of a written plan for securing employment. If the Disability Advisory Committee recommended that Respondent was ready to return to nursing, the Contract allowed Respondent to enter into an agreement for Conditional Licensure, which would allow him to practice as a registered nurse, subject to various terms and conditions. Respondent signed the Contract on or about March 31, 2010.

30. On or about September 15, 2010, Respondent requested to sign a Voluntary Surrender Order because he had ceased to comply with the terms and conditions of the above Contract due to financial problems. On or about September 17, 2010, Respondent signed the Voluntary Surrender Order.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 611209, issued to Christopher Michael Reece;

2. Ordering Christopher Michael Reece to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: December 20, 2011

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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